Figure 1: EHR- based nursing assessment tool

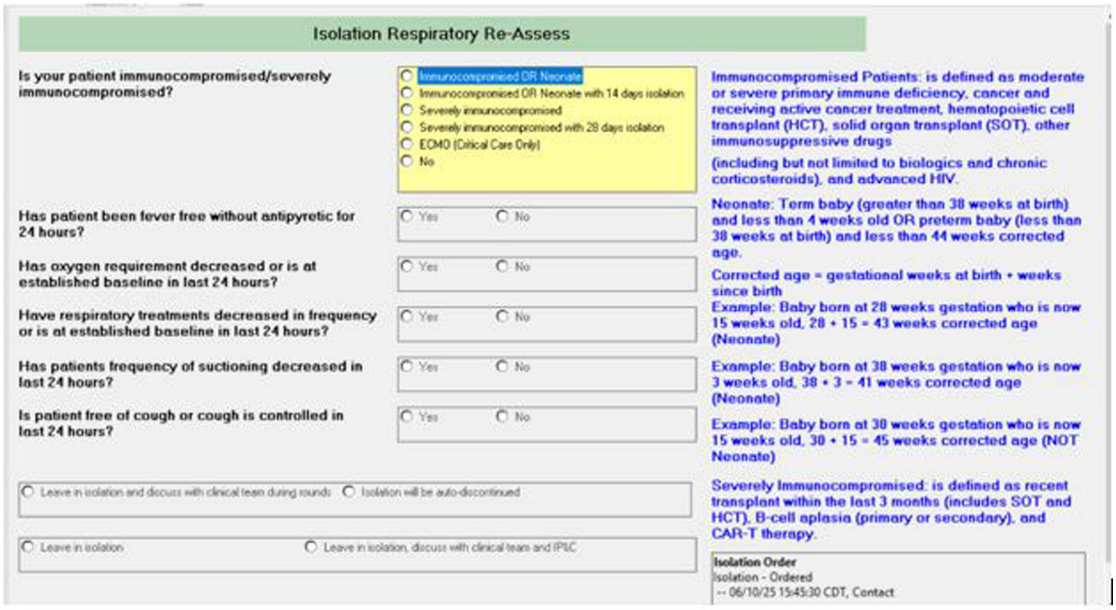
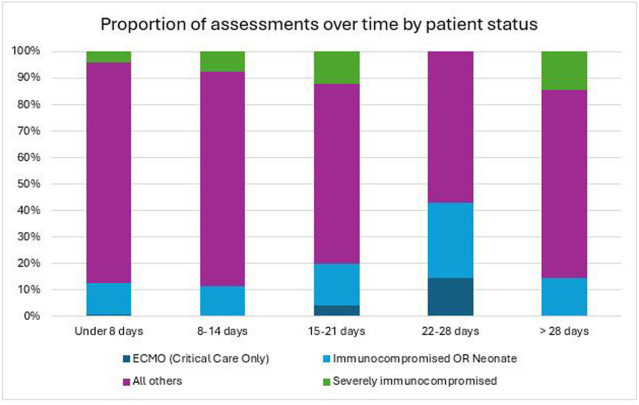


Table 1: Isolation decision based on nursing assessment

Isolation Decision	Number of assessments N=310
Isolation will be auto-discontinued	104 (34%)
Leave in isolation and discuss with clinical team during rounds	155 (50%)
Leave in isolation automated due to status	51 (16%)
ECMO	4 (8%)
Immunocompromised/Neonates	34 (67%)
Severely Immunocompromised	13 (25%)

Figure 2: Proportion of assessments over time by patient status



IP and nursing assessment and de-isolation decisions for patients with underlying clinical conditions who may have a more protracted illness.

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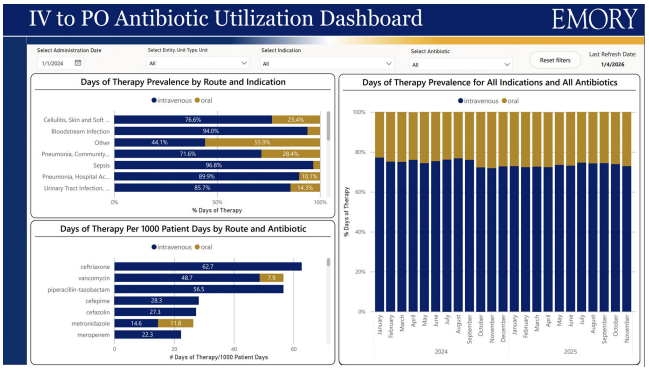
Presentation Type:
Poster Presentation
Subject Category: Quality Improvement

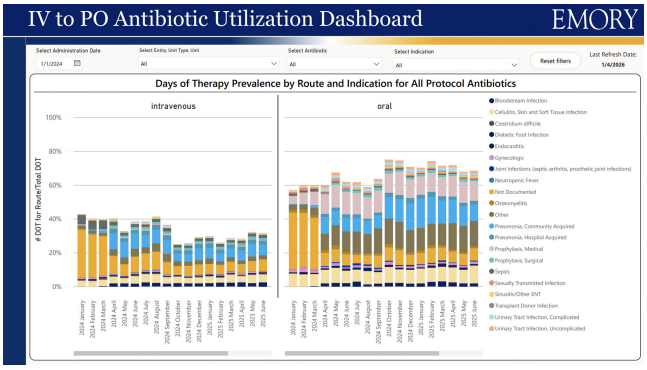
IV to PO Antibiotic Utilization Dashboard: A Clinical Informatics Tool to Optimize Therapy Transitions‡

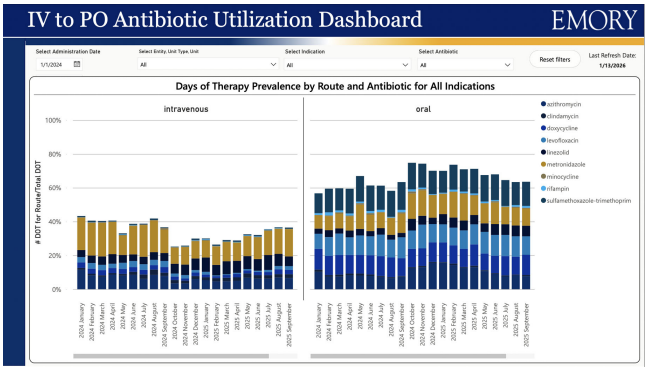
Jada Guilford[1], Sujit Suchindran[2], Kristen Paciullo[3], Leila Hojat[4] and Sarah Green[5]
[1]Emory Healthcare; [2]Emory University School of Medicine; [3]Emory Saint Joseph's Hospital; [4]Emory University Hospital Midtown and [5]Emory University Hospital

Background: Timely conversion of intravenous (IV) antibiotics to oral (PO) therapy remains a core principle of antimicrobial stewardship. Appropriate transition from IV to PO medications reduces the potential for adverse events such as line infections and thrombophlebitis but may also reduce healthcare costs by potentially facilitating a timelier discharge. In addition, IV to PO supports sustainability initiatives by reducing the environmental impact of single-use IV bags and tubing, and PO antibiotics are prepared more quickly by pharmacy and administered easier by nursing, lessening staffing requirements. **Methods:** Emory Healthcare developed a fully automated dashboard to monitor IV to PO transitions and assess adherence to institutional protocols. The dashboard details antibiotic utilization and documented indication for select IV and PO agents among inpatients at Emory Healthcare from January 2024 to the current year-to-date. Selected antibiotics were chosen based on their inclusion in the Emory Healthcare IV to PO Medication Conversion by Pharmacist Protocol. The dashboard integrates data from the electronic health record including antibiotic selection, infection type, and days of therapy. The data is organized into sections and graphs for streamlined viewing and clear interpretation. **Results:** A dashboard was successfully created to monitor IV to PO therapy conversions. The first section (Figure A) shows days of therapy (DOT), which can be filtered by operating unit and indication. The second section (Figure B) displays DOT filtered by route and indication for the specific antibiotics included in the Emory Healthcare IV to PO conversion protocol. The third section (Figure C) displays DOT filtered by route and antibiotic for all indications. The antibiotic and indication charts can

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additionally be filtered to include any combination of antibiotics, indications, facility, unit type, and units. The dashboard also includes tables with antibiotic route of administration data stratified by facility, unit type (ie. oncology, emergency, operating room, acute care), and individual unit. **Conclusion:** The dashboard provides a novel tool for ASPs to continuously assess utilization and adherence to the Emory Healthcare IV to PO conversion protocol. The dashboard is interactive, customizable, and data is readily available, making it a key tool for optimizing stewardship practices. The data can also be used to identify stewardship opportunities, set quality improvement targets, and quickly display information to key stakeholders.

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Presentation Type:
Poster Presentation
Subject Category: Quality Improvement

Increased Contamination of Blood Cultures Collected via New Peripheral IV Start vs Venipuncture‡

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Background: Blood culture contamination leads to increased healthcare costs and patient harm. Routine practice at our institution oftentimes involves placement of a new peripheral intravenous catheter (IV) followed by immediate blood culture collection from the catheter. Published guidelines discourage routine blood culture collection from central venous catheters, but do not address collection from new IV starts. We hypothesized higher contamination rates in cultures collected from new IV starts. To evaluate, mandatory documentation of blood culture collection site was implemented and contamination rates were analyzed. **Methods:** A prospective observational study was conducted from September to December 2025 at a large quaternary medical center. Peripheral blood culture contamination rates were measured using the CLSI definition. Mandatory documentation of collection site was implemented September 2025 and included an option for "new IV start". Contamination rates by collection site were compared using chi-squared tests. An estimated cost of $4,538 for each contamination event was based on pooled published cost analyses data. **Results:** During the study period, 15,926 peripheral blood culture sets were collected and 234 (1.47%) met contamination criteria. Table 1 shows the new IV start contamination rate was significantly higher than all other sites combined (p-value <0.001 with an odds ratio of 1.86 [1.34-2.54]). The difference remained when comparing new IV start to individual anatomic sites. Per year, an estimated 89 contaminations would be avoided if cultures are not obtained from new IV starts with an estimated savings of $403,882 and 267 antimicrobial days. **Conclusions:** At our institution, it is common practice to collect blood cultures immediately after inserting a peripheral IV. The contamination rate of new IV starts was nearly double the contamination rate of dedicated upper extremity venipuncture leading to increased costs and unnecessary antimicrobial use. The large sample size provides robust data that collecting blood cultures from a new IV start should be avoided and this compelling data should be used to update published guidelines.

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Table 1. Blood Culture Contamination Rates by Collection Site (N = 15,926)

Collection Site	Contaminations, N (%)	P-value	Unadjusted Odds Ratio [95% CI]
New IV Start N = 1854 (11.64%)	47 (2.54%)	---	---
Upper Extremity Venipuncture (all sites) N = 14,072 (88.36%)	187 (1.33%)	<0.001	1.86 [1.34-2.54]
Antecubital fossa N = 5298 (33.27%)	71 (1.34%)	<0.001	1.92 [1.31-2.77]
Upper Arm N = 954 (5.80%)	13 (1.36%)	0.038	1.88 [1.03-3.62]
Wrist/Hand N = 3127 (19.63%)	27 (0.86%)	<0.001	2.99 [1.86-4.86]
Forearm N = 4693 (29.47%)	76 (1.62%)	0.017	1.58 [1.09-2.28]

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